it has been one of the unifying aspects of social policy in this country that all older people were covered. I think it is absolutely key that as we tackle this issue of prescription drug coverage, and do it in a bipartisan way, we remember how important the principle of covering all seniors is.

Now, I know there are colleagues on the other side of the aisle who feel strongly about this issue as well. I am very pleased in having teamed up with Senator SNOWE for more than a year. She and I are on a bill together, a bipartisan bill, which offers universal coverage. I also appreciate my colleague from Oregon, Senator SMITH, for being supportive of this effort.

There are a number of reasons why universal coverage is so important, and Senator DASCHLE has identified it as a priority for Senators on this side of the aisle. I want to talk for a moment about why I think it is so key in terms of designing a benefit properly. First, it is absolutely essential to ensure that seniors have as much bargaining power in the marketplace as possible. We have all been hearing from our constituents that many of them cannot afford the cost of prescription medicine. I have been coming to the floor of the Senate and reading from letters where older people, after they are done paying prescription drug bills, only have a couple hundred dollars for the rest of the month to live on.

We are seeing all across this country that many older people simply can't afford their medicine. If we are going to give them real bargaining power in the marketplace—and right now, to belong to an HMO, you have plenty of bargaining power—they can negotiate a good price for you. But if you are an individual senior walking into a pharmacy, you don't have a whole lot of bargaining power. In fact, you are subsidizing those big plans. If we design a prescription drug benefit so as to offer universal coverage, this gives us the largest available group of older people, the largest ''pool of individuals''—to use the language of the insurance industry—for purposes of making sure those older folks really do have bargaining power in the marketplace.

As we address this issue of bargaining power, I happen to think it is important that we do it in a way that doesn't bring about a lot of cost shifting onto other population groups. That is why the Snowe-Wyden legislation uses the model that Federal employees use for the purposes of their health coverage. As we talk about how to design this prescription drug program, I am hopeful we see universal coverage included. Beyond the fact it is what Medicare has been all about since the program began in 1965, it is absolutely key to make sure older people have the maximum amount of genuine bargaining power in the marketplace.

Second, I think if we were to do, as some have suggested—particularly those in the House—which is essentially to not have a program with universal coverage, but hand off a big pot of money to the States, and they could perhaps design a program for low-income people, we will have missed a lot of vulnerable seniors altogether. Their proposal—those who would hand off the money to the States to design a program for low-income people—as far as I can tell, would leave behind altogether seniors, say, with an income of $21,000 or $22,000, essentially a low- to middle-income senior. In most parts of the country, by any calculus, my view is that sum of money is awfully modest altogether. I see these proposals that hand a sum over to the States for low-income people as leaving a lot of seniors with $22,000, $25,000, or $28,000 incomes behind altogether.

If those individuals are taking medicine, say, for a chronic health problem—they might have a chronic health problem due to a heart ailment or something of that nature—they could be spending somewhere in the vicinity of $2,500 per year out of pocket on their prescription medicine. One out of four older people who have chronic illnesses such as the heart ailment are spending $2,500 a year out of pocket on their medicine. As far as I can tell, if they were in that lower- or middle-income bracket, they would simply be left behind altogether under these proposals that would just hand over a pot of money to the States and use this money for low-income people.

Many of the elderly people I described in income brackets of $22,000 or $28,000 and paying for chronic illnesses are the people we are hearing from now saying: If I get another increase in my insurance premium, I am going to simply have to leave my prescription at the pharmacist. My doctor phones it in, and I am not going to be able to afford to go and pick it up.

I think it is extremely important that the design of this program be built on the principle of universal coverage. That is what Medicare has been all about since the program began in 1965. It is what is going to ensure that the seniors have the maximum amount of bargaining power. We can debate issues within that concept of universal coverage so as to be more sensitive to those who have the least ability to pay. I have long believed Lee Iacocca shouldn't pay the same Medicare premium as a widow with an income of $14,000. I think we can deal with those issues as we go forward, if we decide early on that the centerpiece of an effective prescription drug benefit ought to be universal coverage.

There are other important issues we are going to have to discuss. I think there is now growing support for making sure this program is voluntary. When it is voluntary, you avoid some of the problems we are seeing with catastrophic care and ultimately you empower the consumer. It is going to be the consumer's choice in most communities to choose whether they want to go forward participating in this prescription drug program, or perhaps just stay with the coverage they may have. We estimate that perhaps a third of the older people in this country have coverage with which they are reasonably satisfied. If they are, under the kind of approach for which I think we are starting to see support in the Senate, those are folks who would not see their benefits touched; they could simply stay with the existing prescription drug coverage they have today.

Let's go forward. I think Senator DASCHLE in particular deserves credit for trying to bring the Senate together and for trying to reconcile the various bills.

Let's make sure we don't lose sight of the importance of universal coverage. It is key to giving older people real bargaining power in the marketplace—not through a government program but through marketplace forces, the way HMOs and insurance plans do. Focus on keeping the program voluntary.

I know there are colleagues on the other side of the aisle who share similar sentiments as the ones I voiced today. I particularly want to commend my colleagues, Senators SNOWE and SMITH. They have teamed up with me for more than a year now on a proposal that I think can win bipartisan support. In fact, we already have evidence of bipartisan support from the other side of the aisle because we got 54 votes on the floor of the Senate about a year ago for a plan to fund this program.

I intend to keep coming back to the floor of the Senate. Today, I thought it was important to express what Senator DASCHLE spoke on recently, which is universal coverage. I intend to keep coming back to the floor of this body again and again in an effort to build bipartisan support for making sure vulnerable seniors can get prescription drug coverage under Medicare.

I yield the floor.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 p.m. having arrived and passed, the Senate stands in recess until 2:15 p.m.

Thereupon, at 12:41 p.m., the Senate recessed until 2:14 p.m.; whereupon, the Senate reassembled when called to order by the Presiding Officer (Mr. THOMAS).